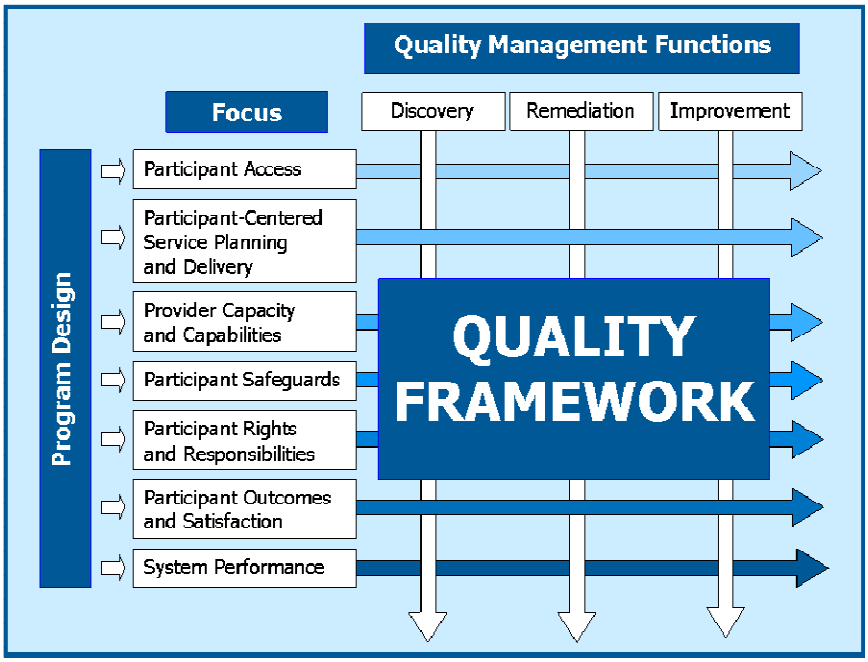
Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Quality Management Strategy

Preface

The DDP has developed and implemented codes, rules and policies designed to ensure compliance with the seven assurances outlined in the CMS Quality Framework document. Significant efforts have been made over the last few years to update and improve various aspects of the DD service system, e.g. the billing and payment system, the client planning process, rates and client allocation methodologies, incident management, et. al. In addition, much effort has been focused on ensuring provider compliance with all these changes, and the development of monitoring protocols designed to ensure that providers are keeping up with the requirements.

In reviewing the standards associated with this section, it is apparent that additional work is needed in two areas:

1. Systems need to be in place to enable the DDP to evaluate the system as a whole in the ongoing analysis of system performance (trend analysis).
2. Systems are needed to effectively evaluate the performance of DDP staff in fulfilling required Department functions and obligations.

Development of solutions for current deficiencies in these areas will be ongoing; DDP's initial efforts follow in this Appendix.

Level of Care Determinations

No adult may be placed on the waiting list or enter waiver services without the review of the documentation supporting a diagnosis of developmental disability by the designated DDP QIS or the Regional Manager. Documentation of developmental disability is maintained by the QIS and also forwarded to the DDP central office to facilitate fiscal and programmatic auditing.

Child and Family service providers are responsible for initially determining if a child referred for IFES meets the state definition for developmental disability under MCA 53-20-202, and if the child has significant deficits in self-help skills (adaptive behaviors), serious medical challenges and/or significant behavior problems. The diagnostic information used to support the child's eligibility determination and need for intensive level services is referenced or included in the referral. Children may be screened only after a referral has been generated, subject to the requirements outlined in the Policy and Procedures for Intensive Family Education & Support Services. Similar standards for referral information are outlined in the DD Case Manager's Handbook for persons seeking adult services. The LOC process conducted by the DDP QIS serves to verify the initial and ongoing presence of developmental disability, and the initial and ongoing need for specific ongoing waiver

supports based on behavioral issues, self-help skill deficits and medical issues.

Documents used for completing initial and ongoing LOC activities are referenced in Appendix B.

Oversight- The DDP does not systematically review the initial and annual LOC documents maintained in the DDP QIS regional and satellite offices. Establishing a DDP internal monitoring process to ensure ongoing compliance with CFR 441.302 (outlined on pages 226 and 227 of the CMS Instructions, Technical Guide and Review Criteria dated 11/05) is needed at this time.

Functionally, this breaks into the following identified needs:

1. Implementation of an ongoing sampling procedure is needed verifying the timely (as defined) establishment of eligibility for DD services. The person is placed on a waiting list. After a person is selected for services, the DDP QIS and Foundation Nurse completes required LOC activities.

Effective 7/1/07, the DDP will implement a sampling process to ensure that eligibility determinations are made in a timely manner. This sampling process will apply to determinations made for children by C&F intake workers and determinations made by DDP QIS staff for persons referred for adult services. Eligibility determination span is defined as the elapsed time between the date a person initially requests a determination, and the date of the eligibility outcome letter generated for the recipient. This sampling process will be incorporated into the DDP CMS QA process for both adult services and children's services. Data will be compiled on a yearly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

2. Implementation of an ongoing sampling procedure is needed verifying the timely (as defined) placement of a person on the waiting list (WL), as verified in the AWACs database.

Effective 7/1/07, the DDP will implement a sampling process to ensure that persons are placed on the WL in a timely manner. This sampling process will apply to WL placement for children and adults in AWACS by the DDP Regional Administrative Assistant. The time span is defined as the elapsed time between the date the provider (for children's services) or case manager (for adult services) submits a written request for placement on the WL, and AWACS date. This sampling process will be incorporated into the DDP CMS QA process for both adult services and children's services. Data will be compiled on a yearly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

3. Implementation of an ongoing sampling procedure is needed verifying the timely (as defined) completion of LOC forms for DD waiver services.

Effective 7/1/07, the DDP will implement a sampling process to ensure that LOC documents are completed in a timely manner. This sampling process will apply to LOC initial evaluations made for children and adults made by DDP QIS staff for persons newly entering the waiver. Timely is defined as completion of the Waiver 1 and Waiver 3 forms within 30 days of the waiver enrollment date listed in the MMIS for sampled recipients. This sampling process will be incorporated into the DDP CMS QA process for both adult services and children's services. Data will be compiled on a yearly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

4. Assignment of DDP personnel or person designated as responsible for conducting these functions.

Effective 7/1/07, the DDP Waiver Specialist will be responsible for updating the CMS QA file with annual information in monitoring of these functions.

5. Development of anchors to enable consistent evaluation of the quality of the eligibility determination and initial LOC process outcomes. This would include a confirmation that the required forms were used, and documented outcomes were based on approved assessments. A sampling process is needed.

Effective 7/1/07, the Clinical Decision Making Worksheet (CDMW) guidelines developed for use by child and family service provider intake staff, and used by DDP QIS staff will be either reviewed (in the case of adult determinations) or applied to the eligibility outcomes for children on a sample basis by the Waiver Specialist. A determination of "DD" under the Montana State definition is the most critical piece of information in the initial LOC process. After the initial LOC is completed, the LOC re-evaluation is designed to ensure that treatment needs continue to mesh with the services being delivered. The DDP Waiver Specialist will be responsible for updating the CMS QA file with annual information in the monitoring eligibility determination outcomes. Specifically, the cognitive assessment and adaptive behavior assessment results for sampled individuals will be compared with the requirements outlined in the CDMW guidelines.

6. Development of an annualized sampling process to establish DDP staff compliance (as indicated above) in completing timely re-evaluations of LOC.

Effective 7/1/07, the DDP will implement a sampling process to ensure that LOC re-determination documents are completed in a timely manner. This sampling process will apply to LOC documents completed for children and adults by DDP QIS staff. Timely is defined as completion of the Waiver 1 (if requested by the QIS) and Waiver 3 forms within 365 days of the previous LOC evaluation, based on the dates of the W-3 forms. Data will be compiled on a yearly basis and maintained in the CMS QA file for the purpose of ongoing tracking and continuous quality improvement.

7. LOC decisions have potential to adversely impact a recipient or family as it relates to the determination of eligibility. In cases when a person is found not DD eligible, eligibility may be contested and the fair hearing process invoked. But it is also possible that persons who aren't DD in accordance with processes used to interpret the state definition could be found eligible for DD services. *The state needs to consider implementing a process to review DD eligibility determination outcomes for the purpose of continuous quality improvement in the updating and improving process and the instruments used to verify eligibility.* This activity is complicated by the fact that tools, indicators and assessments used for establishing DD eligibility for young children are different than those used for adults.

The outcomes of eligibility determinations for persons for persons found "not DD" will be annually sampled by the Waiver Specialist, and data results will be compiled for the purpose of supplementing the information included in the eligibility outcome data maintained under #5, above. This activity will be implemented effective 7/1/07. Decisions made to change any aspect of the LOC or eligibility determination process will be data based.

Service Plans-

Service plans for children and adults must (minimally) address the standards outlined in rule. Plan requirements may be reviewed in ARM 37.34.1401 through 37.34.1407. Plans are based on assessments based on the needs and expressed desires of the individual and/or family.

Service plans address assessed needs and goals, and implemented in accordance with requirements

In children's services
C&F assigned provider staff contact the families and verify satisfaction with the plan and the services being delivered. FSS plans of care are reviewed on a sample basis by the assigned C&F provider staff. The DDP QIS reviews and approves 100% of the annual plans of care for IFES recipients. Problems with plans are noted in the QA review process. Identified problems are addressed at level of the FSS and the reviewing authority. Satisfaction surveys are also completed by the family and returned to the agency. Problems are identified and follow up occurs at this level, if needed. The QIS reviews a sample of IFSP documents as part of the annual QA review to determine if objectives from previous planning meetings were properly addressed and rules governing the plans of care have been followed, including the requirement for the timely implementation of the plan. Finally, the QIS meets with a sample of families served to ascertain overall levels of satisfaction with services.

In adult services- Adult TCM supervisors review samples of plans of care for adult recipients, including reviewing the plans against required standards for content, and timely implementation. External consumer satisfaction surveys are completed annually for every adult waiver recipient by the adult TCM prior to planning meetings. Agency satisfaction surveys are also completed by the recipient, family and/or interested other and returned to the agency. Problems are identified and needed follow up occurs at this level, if needed. Finally, the DDP QIS reviews a sample of plans to ensure that achieved outcomes are satisfactory, and that plans comply with the rule and policy requirements.

Adults, children and families who are not satisfied with their plans of care have several avenues for redress (outlined elsewhere in this document), up to and including requesting a new service provider or case manager, or requesting a fair hearing in the event of the denial of a requested Medicaid reimbursable service. DDP relies on consumer satisfaction data and the review of a sample of plans and family interviews to capture this information annually and to summarize information by provider in the QA report. Results of the review efforts of the DDP QIS and provider systems of internal review are currently focused on solving problems related to the plans at the individual and provider level.

Systems for monitoring plan progress, team/plan responsiveness to changing needs, and the performance of providers and case management in plan follow through.

In children's services, six month review meetings are held by the team to review plan progress and to review the need to adapt the plan based on the changing needs of the family or child. Meetings may be held on more frequent basis, as requested by the family.

Failure by the provider to provide the services as specified could be resolved in a number of ways, including the option of using the on call number to the assigned agency staff and/or calling the assigned Family Support Specialist. Changing needs may require additional service dollars to bolster the plan of care, in situations when the provider is providing the contracted hours of support, but more

support is needed. Requests for additional waiver support dollars require the planning team to agree on the quantity and type of supports and the projected length of time the additional supports will be needed. The case manager would initiate this process. In this case, the service provider would request additional funding from the DDP in the form of a crisis or discretionary grant. In general, the case manager is responsible for follow up, to ensure that services are being delivered and the family is satisfied with the services.

In adult services, quarterly summary reports generated by providers are sent to the Adult TCM to enable data based decisions to be made regarding plan progress. The case manager is responsible for follow up, if needed. Typically, recipients in individualized residential settings would access supports from providers using the on-call system before notifying their case manager. Lack of progress, failure on the part of the provider to deliver the supports specified in the plan, or dissatisfaction with the plan are some of the reasons a special planning meeting would be called by the case manager. Special or emergency planning meetings may be called by the service provider, the recipient, a family member or legal guardian, the case manager, the QIS, or any other person acting on behalf of the recipient. The case manager is responsible for the coordination and scheduling of these meetings.

Failure of the team or the provider to adequately address service delivery issues at the planning team level may result in several possible outcomes:
- The internal agency grievance process is used. The problem may be resolved at the provider level.
- The IP team appeal process is used. This culmination of this process is a decision made at the DDP Program Director level.
- The Department fair hearing process is invoked, if the problem is related to issues outlined in the ARM and MCA (specific references available in Appendix F). The culmination of this process is a decision made by the Department Fair Hearings Officer.
- Significantly, part of the annual planning process is devoted to reviewing the status of objectives set at the previous meeting(s). Dissatisfaction with the delivery of services expressed in the planning document could result (depending upon the issue) in the information being shared with the QIS for follow up. Lack of provider compliance could result in the initiation of the corrective action process.

In children's services, Failure of the team to adequately address issues at the planning team level may result in several possible outcomes:
- The internal agency grievance process is used. The problem may be resolved at the provider level.
- The planning team appeal process is used. This culmination of this process is a decision made at the DDP Program Director level.
- The Department fair hearing process is invoked, if the problem is related to issues outlined in the ARM and MCA (specific references available in Appendix F). The culmination of this process is a decision made by the Department Fair Hearings Officer.
- Significantly, part of the annual planning process is devoted to reviewing the status of objectives set at the previous meeting(s). Dissatisfaction with the delivery of services expressed in the planning document could result (depending upon the issue) in the information being shared with the QIS for follow up. Lack of provider compliance could result in the initiation of the corrective action process.

At this time, there is no external process serving to review total system performance in ensuring compliance in the delivery of supports based on the planning process used in children's or adult services. There is no statewide summary data (other than provider-generated paid claims histories which may reflect only limited service information) serving to track system trends in the delivery of services and supports in accordance with the plans of care. Customer satisfaction data is used to solve individual problems, and the provider aggregates customer satisfaction data from the provider surveys,

but this information is not used by the DDP to track system trends at this time. Service delivery problems continue to be identified and resolved at the individual client level, or at the individual provider level. Data results of the planning process at the provider level may be reviewed for the Annual Quality Assurance Reports completed by the DDP QIS.

The salient issues of the planning process for children's and adult services include:

1. Did the meeting occur within 4 weeks of entry into services?
2. Did annual meetings occur at intervals not exceeding 365 days?
3. Were objectives implemented within the timeframes specified in the plan?
4. In reviewing the objectives set at the previous meeting, did the provider and case manager complete assigned objectives?
5. In the event that rights restrictions or level 1 or level 2 aversive procedures were approved, were the procedures outlined in the Administrative Rules of Montana (ARM) governing these procedures followed?
6. Are consumers, advocates and family members satisfied with the planning outcomes?

Annual plan of care outcome data based on #1-5, above, will be compiled by the case manager supervisors for a sample of recipients. Data summaries will be forwarded to the Waiver Specialist. This data will be maintained in the CMS assurances file, and will be summarized annually by the Waiver Specialist. This requirement will become effective 7/1/07.

The DDP has modified the annual planning process for adults to incorporate personal supports planning features. It is unclear at this time if and when the planning process used with children in IFES will be modified for the purpose of incorporating the personal supports planning features of the adult planning process. Efforts to incorporate the automated reporting of the annual planning process will follow the implementation and finalization of a planning tool on a system wide basis for adults and children. There is no date set for automating the planning process at this time.

Participant Choice of Waiver Services and Institutional Care, and Choice Between/Among Waiver Services and Providers-

Adult Services and Children's Services

The Waiver-5 Freedom of Choice form is specific to the aforementioned choices and is completed for every recipient, annually. It is the responsibility of the assigned case manager (FSS or adult TCM) to complete this document on an ongoing basis with the recipients, legal guardian, or a person who acts on behalf of the recipient. This form and accompanying Explanation of ICF-MR Services and Fair Hearing Rights document, ensure consistency in the sharing of this critical information related to choice between waiver services and institutional care, choice of waiver services available to the participant, and choice of provider for these services.

The choice of institutional care is somewhat limited in Montana, since placement in the ICF-MR requires a court order. This is explained in the explanation of services form, designed to accompany the W-5 form.

At this time, there is no systematic external process serving to review system performance in ensuring compliance in the scheduling and completion of the Waiver 5 form, and DDP QIS staff performance in

ensuring the DDP client waiver files are updated annually with new Waiver 5 forms. The DDP QIS is responsible for ensuring this form is completed annually, and the QIS is responsible for the maintenance of the forms in the client waiver files.

The DDP Waiver specialist will monitor the annual completion of the W-5 form on a sample basis. This requirement will become effective 7/1/06.

Qualified Provider Standards

This section addresses the DDP's need to ensure providers are initially qualified to provider services, and providers maintain these standards in the ongoing provision of services. This includes reviewing the licensure and certification status of required residential facilities (e.g., group homes, foster homes, assisted living facilities) and professional licensure/certification standards for medical and therapy services (e.g., PT, OT, Speech Therapy, Nurse, Dietician, etc). In addition, unlicensed and non-certified direct service providers (persons providing transportation rides, residential habilitation, respite, supported employment, etc.) are reviewed. For persons providing unlicensed or non-certified services, training requirements are key assurances that an employee or contractor is qualified to perform the work.

Children's Services

The Child and Family Qualified Provider Handbook: A Guide for Qualification as a Provider to Developmental Disabilities Services to Children With or at Risk of Developmental Disabilities document outlines the various requirements necessary for a provider to achieve qualified provider status for delivering Intensive Family Education and Support.

Specific to foster home licensure: The qualified provider handbook checklist item #69 states that the provider must have policies, procedures and practices in place to assure that all children's foster homes receiving waiver-funded supports are licensed in accordance with relevant rules, and that copies of the licenses are available upon request. This requirement is reviewed annually under checklist #67, children's waiver services foster homes are licensed in accordance with relevant rules, and copies of the licenses were made available for review. This information is sampled; not every foster home license would be reviewed as part of the annual QA Review, Licensure information is not summarized by the DDP on a statewide basis for trend analysis purposes.

Effective 7/1/07, the licensure status of every children's foster home in which an IFES recipient is being served will be reported in the QA report for the C&F provider serving these children. The QA process will be modified to ensure that follow up occurs in ensuring that foster homes with children receiving DDP-funded supports are licensed.

Specific to FSS Certification: The qualified provider handbook checklist item #27 specifies the requirement that staff who function as Family Support Specialists carry Primary or Comprehensive FSS Certification from DDP/DPHHS, according to requirements in rule, and that all FSSs have access to The Certification Handbook- A Guide for Montana Family Support Specialists. The ongoing certification status of C&F staff is reviewed under checklist item #29 in the comprehensive evaluation process, in which documentation must be provided to verify the certification status of staff. This information is sampled, but is not summarized on a statewide

basis.

Effective 7/1/07, the certification status of every Family Support Specialist providing supports to children in IFES will be verified as part of the DDP annual review. The QA review process will be modified to ensure that follow up occurs in ensuring that Family Support Specialists are certified in accordance with rule and policy.

The qualified provider status of persons providing other waiver services (e.g., respite, transportation, residential habilitation services) is not specifically reviewed although there is a provision (checklist item #39) that requires the agency to have policies, procedures, and practices in place to assure compliance with all applicable federal and state rules, regulations and policies governing the provision of services to children with developmental disabilities.

Failure of a provider to supply evidence of required training and other service requirements (e.g., evidence of background checks) to persons providing waiver reimbursed services is a deficiency in terms of the current Quality Assurance process conducted by the QIS in children's waiver services. This deficiency applies to the review of the qualified provider standards for professional therapy staff as well non-licensed and non-certified staff, and subcontracted staff providing services who are reimbursed by the agency contracting with the DDP. These deficiencies would require correction in accordance with the terms of the review process.

The children's services review process will be modified effective 7/1/07 to include a sampling process for verifying that all direct service providers reimbursed for the provision of waiver services meet the qualified provider requirements, as outlined in Appendix C.

Adult Services

The process for achieving qualified provider status as a provider of adult services includes generic application requirements, and documents specific to the provision of particular services. For example, the state licensure requirements for group homes would be sent to the applicant seeking information about becoming a provider of DD group home services. The document is entitled: State of Montana Department of Public Health & Human Services Disability Services Division Developmental Disabilities Program Qualified Provider Standards For the Delivery of Developmental Disabilities Services to Adults with Developmental Disabilities and Their Families. Section V of this document summarizes the requirements a provider would be held accountable for as part of the initial certification process, and later, during the annual review of the service by the QIS. Section V of the Qualified Provider Application Packet requires a review and understanding of the applicable Administrative Rules of Montana, Montana Code Annotated, MT 0208.90 Waiver language, Federal regulations/rules, DDP policies, contract requirements and the QA review policy and the Incident Management Policy. The ARMs and MCAs, may be viewed on the web at www.dphhs.state.mt.us in the Legal Section under Programs and Services. Not all the DDP policies and current contract requirements are currently posted on the DDP website, but these would be included in the information packet (hard copy or electronic) sent to a potential applicant. The standards are reviewed within nine months of the applicant achieving qualified provider status and annually thereafter.

Monitoring the training delivered workers providing non-licensed/non-certified providers is addressed

in appendices of the quality review process for adult services. Failure of a provider to supply evidence of required training and other service requirements (e.g., evidence of background checks) in the delivery of services to persons served by the waiver is a deficiency in terms of the current quality assurance process conducted by the QIS in children's waiver services. This deficiency applies to the review of the qualified provider standards for professional therapy staff as well non-licensed and non-certified staff, and subcontracted staff providing services reimbursed by the agency contracting with the DDP. These deficiencies would require correction in accordance with the terms of the review process.

The basis for determining compliance with the aforementioned requirements information is the sampling process used when reviewing service providers; not every adult foster home license would be reviewed as part of the annual QA Review. System information verified in accordance with the DDP qualified provider application process, or the quality review process, is not summarized on a statewide basis for trend analysis purposes.

The adult services review process will be modified effective 7/1/07 to include a sampling process for verifying that all direct service providers reimbursed for the provision of waiver services meet the qualified provider requirements, as outlined in Appendix C. In addition, the adult QA process will verify annually that all adult foster care and assisted living providers receiving DDP waiver funded supports are licensed. Effective 7/1/06, the QA process will be modified to ensure the review of the licensure status of every foster home in which the parent is reimbursed for adult foster support.

Monitoring Health and Welfare, and Ensuring Protection from Abuse, Neglect and Exploitation

Children's services

The health, safety and welfare of the child is generally the responsibility of the natural or foster parents. Family Support Specialists and staff from the provider agency visit the recipient in the home setting on an ongoing basis. This limited "traffic flow" is another protection afforded the recipient in ensuring his/her health and safety. The skills of Family Support Specialists in recognizing the signs and symptoms of abuse, neglect and exploitation are critical in this environment. In addition, skills related to the assessment of environmental factors that are statistically linked to the increased likelihood of abuse, neglect and exploitation are also needed. The children's QA process does not evaluate the skills of staff in these areas. Effective 7/1/07, the children's QA process will review what, if any, training is provided to Family Support Specialists in these areas of abuse prevention. These skills may be in place; the DDP QA process will review the provider efforts to provide this training.

The process for ensuring the health and safety of waiver recipients is outlined in previous sections and copies of the annual review and other procedures (e.g., assessment, planning, training, and the coordination and delivery of needed resources and supports, etc.) are available upon request. QA Reviews are shared with the Executive Director and Board Chairperson of the agency, and the DDP Bureau Chief, DDP Regional manager, and DDP Quality Assurance Specialist. The corporation review date is logged on a statewide QA outcome table, serving to give the Regional

Managers and Bureau Chief information regarding DDP's performance in adhering to the annual review schedule. The QA review narrative is posted on the DDP website.

The information is not used to compare performance of the corporation from year to year or for trend analysis. Rather, the review serves to identify problems, bring them to the attention of agency and DDP management and decision makers and to resolve them. The timeframe for developing a system for the compilation and reporting of statewide QA trends (based on the QA reviews of children's services and other information) is not set. It is considered premature to project a date for this activity in the absence of a finalized version of the 373 Q requirements. This activity will be scheduled during the renewal of this waiver prior to 7/1/08.

The current Incident Management Policy, effective 11/05, represents is a concerted effort by the DDP and others to identify and remediate care-giving deficiencies as they arise. Information gleaned from Incident Reports is summarized in an Access database, although *the database is not (as yet) suitable for inferring meaningful statewide trends*. Incident management committees focus on areas of risk on a weekly basis, and results are summarized on a monthly basis and these summaries are shared with DDP staff.

DDP's incident management procedures are currently being modified to enable providers to submit incident reports electronically. The system will ensure that reportable incidents are electronically copied to persons who need them, as outlined in the policy. The software program will enable the compilation of trend data based on the needs of the reviewer, including summaries by region, provider and recipient. The integrity of this process is dependent upon the reporting by persons providing direct client services. The electronic reporting of incidents should be fully implemented statewide by 7/1/07.

Adult Services

The health, safety and welfare of the adult is generally the responsibility of DDP-funded staff providing primary care giving. The Adult Targeted Case Managers visit the recipient in the residential setting on an ongoing basis. This limited "traffic flow" is another protection afforded the recipient in ensuring his/her health and safety. The skills of the case manager in recognizing the signs and symptoms of abuse, neglect and exploitation are critical in this environment. In addition, skills related to the assessment of environmental factors that are statistically linked to the increased likelihood of abuse, neglect and exploitation are needed. The adult QA process currently does not evaluate the skills of staff in these areas. Effective 7/1/07, the DDP review of case management services will review what, if any, training is provided to case management staff in abuse prevention.

The process for ensuring the health and safety of waiver recipients is outlined in previous sections and copies of the annual review and other procedures (e.g., assessment, planning, training, and the coordination and delivery of needed resources and supports, etc.) are available upon request. QA Reviews are shared with the Executive Director and Board Chairperson of the agency, and the DDP Bureau Chief, DDP Regional manager, and DDP Quality Assurance Specialist. The corporation review date is logged on a statewide table, serving to give the Regional Managers and Bureau Chief information regarding DDP's performance in adhering to the annual review

schedule. The QA review narrative for each corporation is posted on the DDP website. The information is not used to compare performance of the corporation from year to year or for trend analysis. Rather, the review serves to identify problems, bring them to the attention of agency and DDP management and decision makers and to resolve them.

Reviews of agencies occur annually, but information is compiled during the year on an ongoing basis. Information is based on incident reports, planning meeting documents, incident management committee notes, consumer satisfaction surveys conducted by the DDP QIS, customer surveys collected by the agency and reviewed by the QIS and other information as outlined in the QA Review process. The QA review affords the reviewer an opportunity to gain a composite perspective of the "year in review" based on summarized information.

The current Incident Management Policy, effective 11/05, represents a concerted effort by the DDP and others to identify and remediate care-giving deficiencies as they arise. Information gleaned from Incident Reports is summarized in an Access database. This database is in the process of being fully developed to give the DDP the capacity to project statewide trends. Incident management committees focus on areas of risk on a weekly basis and meeting minutes are summarized in the provider Monthly Trend Report. Copies of these reports are sent to the DDP regional offices.

DDP's incident management procedures are currently being modified to enable providers to submit incident reports electronically. The system will ensure that reportable incidents are electronically copied to persons who need them, as outlined in the policy. The software program will enable the compilation of trend data based on the needs of the reviewer, including summaries by region, provider and recipient. The integrity of this process is dependent upon the reporting by persons providing direct client services. The electronic reporting of incidents should be fully implemented statewide by 12/1/07.

Administrative Authority

Appendix A-5 identifies the contracted entities responsible for specific operational and administrative waiver functions. The DDP contracts with agencies providing Adult Targeted Case Management services and Registered Nurses under the Mountain Pacific Quality Health Foundation Contract (also known as the "Foundation"). These contracts outline the service expectations and the terms of reimbursement. The DDP is responsible for developing the administrative rules and policies defining the service and qualified provider standards. The continuation of these contracts on a yearly basis is dependent upon the service providers fulfilling the terms and conditions of the contracts.

Copies of the Foundation contract governing the provision of Registered Nurses in the performance of LOC activities are available upon request. Copies of the contract boilerplate language, and the appendices specific to the provision of Family Supports Coordination (children's case management) and Adult Targeted Case Management (a Montana State Plan service) are available upon request.

Oversight of the Foundation contract is currently the responsibility of the DDP Waiver Specialist, who reviews and signs off on the monthly invoices and annually renegotiates the contract. Contract oversight of the case management contracts is performed by the DDP Regional Managers, who are responsible for ensuring that services are billed and paid in accordance with the established practices. A small contract is maintained with a private billing agency, enabling State Plan case management services to be entered in the MMIS. The Regional Managers are responsible for renegotiating the case management contracts annually.

Problems are resolved as they arise, often in concert with an agency director, a DDP Regional Manager, a DDP QIS and less frequently, the DDP Bureau Chief and/or Program Director.

Financial Accountability

The requirements associated with audits and financial reviews, required reports and the review of these reports by DDP staff and auditors from the QAD (and sometimes Legislative Fiscal Analysts) are outlined elsewhere in this document. The review of a sample of paid claims histories against the documentation maintained by the provider for services delivered is a part of the QA process used by the DDP QIS to evaluate the delivery of adult services and children's services. As part of reviewing paid claims histories, and effective 7/1/06, the DDP QA process will include the review of the delivery of waiver funded services potentially reimbursable under the State Plan to ensure the waiver is the payer of last resort in all cases.

The QA process is summarized yearly, but the gathering of information, onsite reviews and the desk review of information is stretched out over an extended period of time. Audits are reviewed by DDP Fiscal staff for the purpose of resolving individual issues and/or systemic billing and payment issues, in concert with agency business managers/ accounting staff.

The rates reimbursement project currently being piloted in Region 2, and the AWACs billing and payment system re-write (designed to provide the flexibility to meet the demands of future billing and data tracking needs for perhaps the next 10 years) involves contracted personnel (Davis/Deshaies and Maximus), DDP and DPHHS program staff, technical and software specialists, programmers and significant numbers of DDP management and line staff and provider staff working together before either of these projects can be fully implemented on a statewide scale.

Roles and Responsibilities

The DDP has a broad base of input in terms of various ongoing projects designed to lead to significant improvements in services to participants. The "Quality Council" includes self-advocates, Montana Advocacy Program, parents, providers and DDP staff involved in the Quality Assurance Process. DDP Management is ultimately responsible for ensuring the Quality Assurance Review Process meets the needs of the DDP, consumers and various funding sources and constituencies. Likewise, the implementation of a new adult planning process (Personal

Support Planning) involves a contractor (Program Designs) and a myriad of representatives including consumers and families, MAP, providers, DDP staff, case managers and others. The Incident Management System is another recent system improvement effort, involving staff from the ICF-MR, a consultant (Dale Dangremond) and a large contributor base to ensure the needs of DDP, CMS, providers and consumers would be met. The data collection methodology for this project is still a work in progress and may be linked to the AWACs rewrite.

Current efforts to amend this waiver involved a formal request for input to a large number of system stakeholders, including case managers, People First members and MAP represenatives, DD service providers and others. All waiver amendment input was considered, discussed and selectively approved by DDP management and others before this project was initiated. Further effort is needed to systematically enable the gathering of participant, family and service provider input and to develop a conduit for this information to decision makers involved in the waiver amendment process.

DDP will be addressing this issue as part of the current Strategic Planning Across Montana meetings series. Effective 7/1/07, DDP will implement a statewide "open conduit" enabling the free flow of waiver improvement ideas from any and all system participants to the DDP Waiver Specialist. At this time, the DDP is unsure of the best way(s) to accomplish this goal. The DDP Waiver Specialist will compile this information for the review of, and decision-making by, the DDP management team.

DDP does not currently operate with a comprehensive Quality Management System (QMS) driven by the trend analysis of comprehensive system data serving to:
1. Establish priorities and develop strategies for remediation and improvement; and
2. Generate quality management reports based on total system analysis; and
3. Implement, on a scheduled basis, changes in the QMS based on trend reports.

At this time, DDP, the Information Services Bureau and Maximus (redesign contractor) are engaged in updating the AWACS billing and payment system to enable the billing system to capture the required 373 S data, and to incorporate data elements for the rates methodology project, among other things. Currently, DDP generates the required 372 Report fiscal data via Annual Expenditure Report (AER) process. Updating the AWACS database to include all the elements and fields necessary to produce a 373 Q Report based on system data queries was recently discussed with Maximus staff. This requirement is beyond the scope of the DDP's contract with Maximus at this time.

Despite the lack of a formal QMS incorporating the automation of data necessary for the DDP to efficiently implement and maintain systems supporting trend analysis, it should be recognized that the DDP has been moving forward with unprecedented effort in improving various aspects of the DD service delivery system. The current level of activity in system redesign is nothing less than remarkable. Better options, choices, lifestyles and protections/safeguards for recipients have served as the primary catalysts for this change, along with recommendations and input from assigned staff in the CMS regional and central offices.